

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0031914</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																	
Facility Name: <u>Montgomery Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																	
Address: <u>215 N. Walnut</u> <u>Nokomis</u> <u>62075</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																	
County: <u>Montgomery</u>																			
Telephone Number: <u>(217) 563-7013</u> Fax # ()																			
IDPA ID Number: <u>37-1103855008</u>																			
Date of Initial License for Current Owners: <u>03/06/87</u>																			
Type of Ownership:																			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT																			
<input type="checkbox"/> Charitable Corp.																			
<input type="checkbox"/> Trust																			
IRS Exemption Code																			
<input checked="" type="checkbox"/> PROPRIETARY																			
<input checked="" type="checkbox"/> Individual																			
<input type="checkbox"/> Partnership																			
<input type="checkbox"/> Corporation																			
<input type="checkbox"/> "Sub-S" Corp.																			
<input type="checkbox"/> Limited Liability Co.																			
<input type="checkbox"/> Trust																			
<input type="checkbox"/> Other																			
GOVERNMENTAL																			
<input type="checkbox"/> State																			
<input type="checkbox"/> County																			
<input type="checkbox"/> Other																			
In the event there are further questions about this report, please contact: Name: <u>Patrick E. Bell, CPA</u> Telephone Number: <u>(217) 465-6494</u>		<table border="1"> <tr> <td rowspan="2"> Officer or Administrator of Provider </td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4"> Paid Preparer </td> <td>(Type or Print Name) <u>Scott Cornell</u></td> </tr> <tr> <td>(Title) <u>Owner</u></td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Patrick E. Bell, CPA</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Larsson, Woodyard & Henson, LLP</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(217) 465-6494</u> Fax # <u>(217) 465-6499</u></td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Scott Cornell</u>	(Title) <u>Owner</u>	(Signed) _____	(Date) _____		(Print Name and Title) <u>Patrick E. Bell, CPA</u>		(Firm Name & Address) <u>Larsson, Woodyard & Henson, LLP</u>		(Telephone) <u>(217) 465-6494</u> Fax # <u>(217) 465-6499</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Officer or Administrator of Provider	(Signed) _____																		
	(Date) _____																		
Paid Preparer	(Type or Print Name) <u>Scott Cornell</u>																		
	(Title) <u>Owner</u>																		
	(Signed) _____																		
	(Date) _____																		
	(Print Name and Title) <u>Patrick E. Bell, CPA</u>																		
	(Firm Name & Address) <u>Larsson, Woodyard & Henson, LLP</u>																		
	(Telephone) <u>(217) 465-6494</u> Fax # <u>(217) 465-6499</u>																		
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Montgomery Terrace# 0031914 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,152</u>	<u>366</u>		<u>5,518</u>	13
14	TOTALS	<u>5,152</u>	<u>366</u>		<u>5,518</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.23%

D. How many bed-hold days during this year were paid by Public Aid?

262 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started March 1, 1987

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date March 11, 1987 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: N/A

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Montgomery Terrace

0031914

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	14,616	366	910	15,892		15,892		15,892		1
2	Food Purchase		29,437		29,437		29,437	(456)	28,981		2
3	Housekeeping	12,917	1,178		14,095		14,095		14,095		3
4	Laundry		458		458		458		458		4
5	Heat and Other Utilities			12,268	12,268		12,268	1,292	13,560		5
6	Maintenance	8,493	437	5,257	14,187		14,187	750	14,937		6
7	Other (specify):*										7
8	TOTAL General Services	36,026	31,876	18,435	86,337		86,337	1,586	87,923		8
	B. Health Care and Programs										
9	Medical Director			5,100	5,100		5,100		5,100		9
10	Nursing and Medical Records	121,074	527	8,550	130,151	(2,350)	127,801	695	128,496		10
10a	Therapy			695	695		695		695		10a
11	Activities	11,440	4,661		16,101		16,101	184	16,285		11
12	Social Services			285	285		285		285		12
13	Nurse Aide Training			835	835	2,350	3,185		3,185		13
14	Program Transportation			3,252	3,252		3,252	134	3,386		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	132,514	5,188	18,717	156,419		156,419	1,013	157,432		16
	C. General Administration										
17	Administrative	11,098		18,000	29,098		29,098		29,098		17
18	Directors Fees										18
19	Professional Services			3,446	3,446		3,446		3,446		19
20	Dues, Fees, Subscriptions & Promotions			1,572	1,572		1,572		1,572		20
21	Clerical & General Office Expenses	15,815	533	23,650	39,998		39,998	(15,636)	24,362		21
22	Employee Benefits & Payroll Taxes			24,536	24,536		24,536	5,424	29,960		22
23	Inservice Training & Education										23
24	Travel and Seminar			995	995		995		995		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			6,094	6,094		6,094	871	6,965		26
27	Other (specify):*										27
28	TOTAL General Administration	26,913	533	78,293	105,739		105,739	(9,341)	96,398		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	195,453	37,597	115,445	348,495		348,495	(6,742)	341,753		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Montgomery Terrace

#0031914

Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											30
	Depreciation			2,012	2,012		2,012	7,903	9,915			
31	Amortization of Pre-Op. & Org.											31
32	Interest			306	306		306	338	644			32
33	Real Estate Taxes			5,755	5,755		5,755		5,755			33
34	Rent-Facility & Grounds			50,400	50,400		50,400		50,400			34
35	Rent-Equipment & Vehicles							1,867	1,867			35
36	Other (specify):*											36
37	TOTAL Ownership			58,473	58,473		58,473	10,108	68,581			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,784	29,784		29,784		29,784			42
43	Other (specify):* Resident Supplies		1,077		1,077		1,077	(1,077)				43
44	TOTAL Special Cost Centers		1,077	29,784	30,861		30,861	(1,077)	29,784			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	195,453	38,674	203,702	437,829		437,829	2,289	440,118			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,825	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(456)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(18,898)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,629)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	19,918		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 19,918		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 2,289		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Montgomery Terrace

ID#

08/31/14

Report Period Beginning:

01/01/00

Ending:

12/31/00

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90

Summary A

Facility Name & ID Number	Montgomery Terrace	#	0031914	Report Period Beginning:	01/01/00	Ending:	12/31/00
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I							

[illegible]

Summary B

12/31/00

[illegible]

STATE OF ILLINOIS

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Facility Name & ID Number Montgomery Terrace# 0031914

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Scott Cornell	100.00	See Attached	Geneva, FL	Angela-Barr Cornell	Geneva, FL	Empl-Clerical

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Admin Management	\$ 18,000	Scott Cornell	100.00%	\$ 18,000	\$	1
2	V							2
3	V							3
4	V	Sch VIII						4
5	V	Central Office	19,918			19,918		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 37,918			\$ 37,918	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Terrace # 0031914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Scott Cornell	Owner	Admin.Mgmt.	100.00	72,000				\$ 18,000	17	1
2	Angela Barr-Cornell	Spouse of Owner	Salary-Clerical	0.00	37,287				9,322	21	2
3											3
4											4
5	(1) Total hours per work week		35			(3) Total hrs per week			40		5
6	Hrs devoted to Nursing Home Mgmt		35			Hours devoted to clerical			40		6
7	Hrs devoted to Montgomery Terrace		5.8			Hours devoted to East Side			40/5=8		7
8											8
9	(2) 5.8/35		16.6			(4) 8/40			20		9
10											10
11											11
12											12
13								TOTAL	\$ 27,422		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Terrace # 0031914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Scott Cornell
 Street Address 311 Proctor Ct.
 City / State / Zip Code Geneva, FL 32732
 Phone Number ()
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Attached								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Terrace# 0031914

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Soy Capital Bank & Trust		X	Van	\$602.00	12/4/97	\$ 22,004	\$	12/04/00	8.7500	\$ 306	1	
2												2	
3												3	
4	Central Office										338	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$602.00		\$ 22,004	\$			\$ 644	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 22,004	\$			\$ 644	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Montgomery Terrace**# **0031914** Report Period Beginning: **01/01/00** Ending: **12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	5,146	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	5,450	2
3. Under or (over) accrual (line 2 minus line 1).	\$	304	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	5,451	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	5,755	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	4,838	8		FOR OFF USE ONLY	
	1996	5,026	9			
	1997	5,143	10	13	FROM R. E. TAX STATEMENT FOR 1999	13
	1998	5,146	11	14	PLUS APPEAL COST FROM LINE 5	14
	1999	5,450	12	15	LESS REFUND FROM LINE 6	15
				16	AMOUNT TO USE FOR RATE CALCULATION	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:
 4,030

B. General Construction Type:
 Exterior
 Brick/Vinyl
 Frame
 Wood/Gypsum Boar
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 15,600

2. Number of Years Over Which it is Being Amortized:
 5

3. Current Period Amortization:
 Fully Amortized

4. Dates Incurred:
 09/01/86

Nature of Costs:

 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2		N/A			2
3	TOTALS	#VALUE!		\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SPRINKLER CHANGES	1987		575		10			575	9
10		STORAGE SHED	1987		509		10			509	10
11		FIRE ALARM REPAIRS	1989		810		10			810	11
12		LANDSCAPING	1990		850	50	10	43	(7)	624	12
13		CARPET	1992		3,597		10	360	360	3,597	13
14		GILLEN PROPERTIES PAINTING	1993		500	22	10	50	28	500	14
15		WALLPAPER	1995		372		10	37	37	372	15
16		FLOORING	1996		818	64	10	82	18	658	16
17		AIR CONDITIONER	1996		1,396	130	10	140	10	1,072	17
18		CARPETING/FLOORING	1997		2,731	210	10	137	(73)	839	18
19		WINDOW AIR CONDITIONER	1998		1,647		10	165	165	1,647	19
20											20
21											21
22											22
23		Central Office						6,078	6,078		23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 13,805	\$ 476		\$ 7,092	\$ 6,616	\$ 11,203	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Terrace

0031914

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 7,890	\$ 748	\$ 682	\$ (66)		\$ 6,475	37
38	Current Year Purchases	1,053	37	24	(13)		37	38
39	Fully Depreciated Assets	10,643		674	674		10,643	39
40								40
41	TOTALS	\$ 19,586	\$ 785	\$ 1,380	\$ 595		\$ 17,155	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Transportation	1997 DODGE VAN	1997	\$ 22,004	\$ 461	\$ 1,153	\$ 692	5	\$ 21,312	42
43	Transportation	1997 Dodge Van	2000	5,805	290	290		5	290	43
44										44
45										45
46	TOTALS			\$ 27,809	\$ 751	\$ 1,443	\$ 692		\$ 21,602	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 61,200	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 2,012	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 9,915	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 7,903	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 49,960	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54			N/A		54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60		N/A	60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	
2	Books and Supplies		50		50
3	Classroom Wages (a)	512	1,662		2,174
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		961		961
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 512	\$ 2,673	\$	\$ 3,185
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,185			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	12

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs		N/A			#VALUE!		7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12										
13	Other (specify):									13
14	TOTAL			\$		\$	\$	#VALUE!	\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Montgomery Terrace

0031914

Report Period Beginning: 01/01/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 16,869	\$ 81,102	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	68,480	387,866	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,503	22,515	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 89,852	\$ 491,483	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,805	147,108	15
16	Equipment, at Historical Cost	47,395	265,214	16
17	Accumulated Depreciation (book methods)	(49,960)	(320,930)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,240	\$ 91,392	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 101,092	\$ 582,875	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,056	\$ 85,326	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		13,731	29
30	Accrued Salaries Payable	3,866	30,133	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,353	4,012	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,451	24,976	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Workshop		16,667	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 23,726	\$ 174,845	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		12,409	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 12,409	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 23,726	\$ 187,254	46
47	TOTAL EQUITY(page 18, line 24)	\$ 77,366	\$ 395,621	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 101,092	\$ 582,875	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,063	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,063	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	77,910	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(73,607)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 4,303	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 77,366	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 515,739	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 515,739	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 515,739	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	86,337	31
32	Health Care	156,419	32
33	General Administration	105,739	33
B. Capital Expense			
34	Ownership	58,473	34
C. Ancillary Expense			
35	Special Cost Centers	1,077	35
36	Provider Participation Fee	29,784	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 437,829	40
41	Income before Income Taxes (line 30 minus line 40)**	77,910	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 77,910	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Montgomery Terrace**# **0031914**Report Period Beginning: **01/01/00**Ending: **12/31/00**

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	11,468	12,007	90,177	7.51	5
6	Nurse Aide Trainees	274	274	2,350	8.58	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,610	1,644	11,440	6.96	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,798	1,844	14,616	7.93	15
16	Dishwashers					16
17	Maintenance Workers	599	599	8,493	14.18	17
18	Housekeepers	1,744	1,744	12,917	7.41	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	628	628	11,098	17.67	22
23	Office Manager					23
24	Clerical	702	702	15,815	22.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,016	2,016	28,547	14.16	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,839	21,458	\$ 195,453 *	\$ 9.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	26	\$ 910	1-3	35
36	Medical Director	Mo. Fee	5,100	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	248	5,066	10-3	38
39	Pharmacist Consultant	Mo. Fee	1,725	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	11	506	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	189	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	8	285	12-3	45
46	Other(specify)				46
47	Dental Expense	Per Visit	1,279		47
48	Psyc. Consultant	Mo. Fee	480	10-3	48
49	TOTAL (lines 35 - 48)	297	\$ 15,540		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Anna Brackenbush	Adm.	0.00	\$ 5,409	Workers' Compensation Insurance	\$	3,743	IDPH License Fee	\$ 400
Susan Cappellin	Adm.	0.00	5,689	Unemployment Compensation Insurance		3,174	Advertising: Employee Recruitment	998
				FICA Taxes		14,844	Health Care Worker Background Check	
				Employee Health Insurance		5,424	(Indicate # of checks performed <u>6</u>)	60
				Employee Meals			Dues & Subscriptions	114
				Illinois Municipal Retirement Fund (IMRF)*				
				Simple IRA		2,775		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 11,098					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount					
Scott Cornell-Admin. Mgmt.			\$ 18,000				Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 18,000	TOTAL (agree to Schedule V,	\$	29,960	TOTAL (agree to Sch. V,	\$ 1,572
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Larsson, Woodyard & Henson, LLP	Accounting		\$ 3,446				Out-of-State Travel	\$
							In-State Travel	773
							Seminar Expense	
							American Red Cross	67
							IHCA Seminar	125
							UTLAUT Health Seminar	30
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 3,446				line 24, col. 8)	\$ 995

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

(Continued from Page 1)													
1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4					N/A								
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p>Facility Name & ID Number <u>Montgomery Terrace</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>NO</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>NO</u> If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>YES</u> What was the average life used for new equipment added during this period? <u>7</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>N/A</u> Line _____</p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u> If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES _____ NO <u>X</u></p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>29,784</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>YES</u> If YES, attach an explanation of the allocation. _____</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>0031914</u> Report Period Beginning: <u>01/01/00</u> Ending: <u>12/31/00</u></p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>N/A</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>NO</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions _____</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? _____ Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>NO</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____ c. What percent of all travel expense relates to transportation of nurses and patients? <u>100%</u> d. Have vehicle usage logs been maintained? <u>NO</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>YES</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>NO</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>0</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>NO</u> Firm Name: <u>N/A</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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